DOCUMENT RESUME

ED 256 254 HE 018 318

TITLE	Primary Health Care in Undergraduate Medical Education. Report on a World Health Organization Meeting (Exeter, England, July 18-22, 1983).
INSTITUTION	World Health Organization, Copenhagen (Denmark). Regional Office for Europe.
REPORT NO	ISBN-92-890-1027-4
PUB DATE	84
NOTE	74p.
AVAILABLE FROM	WHO Publications Centre USA, 49 Sheridan Avenue, Albany, NY 12210.
PUB TYPE	Collected Works - Conference Proceedings (021) -- Reports - Descriptive (141)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Clinical Teaching (Health Professions); College Role; Educational Objectives; Educational Planning; *Foreign Countries; Government School Relationship; Higher Education; *Medical Education; Preventive Medicine; *Primary Health Care; *Public Health; *School Community Relationship; Seminars; *Undergraduate Study

ABSTRACT

Ways to improve the training of undergraduate medical students in primary health care are identified, based on a seminar organized by the World Health Organization Regional Office for Europe and the Government of the United Kingdom. Primary health care is concerned with preventing and treating illness and promoting health, based on applying biomedical, behavioral, and health services research and public health experience. Obstacles to reorienting medical education to primary health care include: confusion about the objectives of undergraduate medical education; isolation of medical schools from communities; lack of intersectoral coordination for health purposes; departmentalism in medical education; and political, professional, and commercial resistance to primary health care. Conditions that are needed to reorient medical education include: government commitment, health resources planning, support from medical schools, educational planning, and evaluation procedures. Also discussed are the use of the community as a training setting for primary health care, and orienting the medical school toward primary health care. Appendices include summaries in French, German, and Russian and a list of five questions that were provided to seminar participants. (SW)

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The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 32 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

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World Health Organization
Regional Office for Europe
Copenhagen

Primary health care in undergraduate medical education

Report on a WHO meeting

Exeter, 18–22 July 1983

ICP/EDS 009

ISBN 92 890 1027 4

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PRINTED IN DENMARK

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INTRODUCTION

In 1980, the countries of the European Region of the World Health Organization, through their WHO Regional Committee, adopted a regional strategy for attaining health for all by the year 2000 (EUR/RC30/R8). This strategy is the European component of the corresponding global strategy, adopted by the World Health Assembly in 1981. It has three main components: the promotion of lifestyles conducive to health, the reduction of preventable conditions, and the provision of adequate health care accessible to all. It relies heavily for its implementation on primary health care as defined by the International Conference on Primary Health Care held at Alma-Ata, USSR, in 1978. This reliance on primary health care as "the key to the attainment of health for all by the year 2000" implies "major changes in professional practice and the organization and financing of health care" and "a fundamental reorientation of medical and nursing education".

The Member States of the WHO European Region are at different stages of preparing national strategies and corresponding primary health care approaches, and discussions have begun about the changes in professional practice that these will demand and the consequent reorientation that will be needed in medical and nursing education.

In order to assist national health and education authorities to determine how medical education will need to be modified and supported so as to provide for the training of undergraduate medical students for primary health care, the WHO Regional Office for Europe in collaboration with the Government of the United Kingdom invited a group of WHO temporary advisers to take part in a seminar on primary health care in undergraduate medical education (Annex 3). It was held at the Department of General Practice of the Postgraduate Medical Centre of the University of Exeter, from 18 to 21 July 1983. Its task was to derive from the regional strategy the new roles and functions of primary health care medical practitioners, and to indicate in broad terms the consequent changes that will be needed in undergraduate medical education as

regards its structure, organization, methods, and relations with other university disciplines and with communities.

At the formal opening of the seminar Lord Glenarthur, Under-Secretary of State at the Department of Health and Social Security, welcomed the participants on behalf of Her Majesty's Government. He referred to the growth in the United Kingdom of primary medical care teams and, in line with the Declaration of Alma-Ata, to the increasing attention being given to the prevention of ill health and the promotion of good health. There was evidence that the general population of the United Kingdom was becoming increasingly aware of its capacity to protect its own health, and it was logical that the fundamental reorientation of medical education which the regional strategy implied would provide for doctors to be trained in ways of promoting and supporting community responsibility for health, and of cooperating with other professions and sectors to bring under control the main health problems of communities.

The seminar was opened by Dr A. Wojtczak, Director of the Service of Research, Planning and Human Resources at the WHO Regional Office for Europe, on behalf of the Regional Director, Dr Leo A. Kaprio.

Dr D.J. Pereira Gray was elected Chairman of the group, and Dr E. Kum and Dr M. Szatmari were elected Vice-Chairmen. Dr J. Gallagher, Co-secretary of the meeting, was elected Rapporteur.

THE SEMINAR IN THE CONTEXT OF THE REGIONAL STRATEGY FOR HEALTH FOR ALL

In preparation for the seminar, the Regional Office had sent each participant a copy of the Regional Strategy document and other background material (see References), as well as a set of five questions (Annex 2) designed to elicit their preliminary views about the main issues to be discussed. The responses received, from 14 of the 19 participants, were used to prepare a working paper. Much of this material, which came up again in the discussions and recommendations, is incorporated in this report.

The participants were reminded that the regional strategy and the concept of primary health care upon which it relies call for measures which go far beyond current practices in both health care and the education of health professionals. It was pointed out that primary health care in the comprehensive sense indicated by the Declaration of Alma-Ata is a still largely untried concept or group of concepts in the health care services and educational institutions of the European Region. Nowhere yet have there been the "major changes in professional practice and the organization and financing of health care" or the "fundamental reorientation of medical and nursing education" referred to in the regional strategy document.

Primary health care in its post Alma-Ata sense implies not merely progressive but what may seem to be revolutionary measures in health care and medical education. For purposes of the seminar, participants were advised that they should not feel bound by the limits of the health care or educational systems of which they were part. By considering what might seem to be even idealistic solutions they would be indicating directions that countries could take and options that they could consider. The countries of the European Region would be moving forward from a great diversity of positions: what some might regard as impractical or unattainable, others might find feasible. Each country's pattern of primary health care, and consequently the ways in which its medical education system will need to be modified, will depend largely on how it visualizes the attainment of the goal of health for all.

For the purposes of the seminar it was important to recognize that medical schools could become extremely important partners with government in developing and putting into operation the concepts of primary health care. As the Alma-Ata Conference recognized, primary health care has to be a scientifically sound and socially acceptable form of health care related to people's needs rather than only to the concerns of the health professions. It differs from primary medical care in that it is concerned not only with treating the sick but also with promoting health and preventing ill health, often by means which are not yet regarded as health care measures. It is based on the application of biomedical, behavioural

and health services research and public health experience. It addresses the main health problems of communities, and since these cannot be prevented or controlled by the health sector alone it will incorporate contributions of other sectors that can play a part in preventing disease and promoting and protecting health. This is what is meant by multisectoral (or intersectoral) action or cooperation in primary health care. Medical schools, with other university faculties and disciplines, can play crucial parts in assuring the scientific soundness of primary health care in all these respects, and particularly, as new dimensions of health care, in helping communities to exercise responsibility for their own health and involving sectors other than the health sector in health promotion.

The seminar's task was to consider how these new demands that will be made on primary health care practitioners might be reflected in undergraduate medical education - in its internal structure and organization, and its relations with health services and communities, as well as in its teaching and learning methods, and in its research. From their study of the regional strategy for health for all, the participants considered it would be for medical schools as total entities, rather than as specific departments, to carry out the fundamental reorientation of medical education called for by the regional strategy, so that competency in primary health care could become the principal objective of the undergraduate curriculum.

According to the concept of primary health care upon which the regional strategy depends, the new or extended roles and functions for which primary care practitioners will need to be trained refer mainly to cooperation with communities, families, and individuals in assuming responsibility for their own health; cooperation with, and stimulating the collaboration of, sectors other than the health sector in promoting health and preventing disease and disability; and extending health care coverage to underserved and vulnerable and high risk groups. These will be in addition to high quality clinical competency, which will always be an essential element of primary health care. The new roles and functions will demand new forms of medical practice, including multidisciplinary and multisectoral teamwork in

health care. They will incorporate epidemiological, biostatistical, psychological and sociological elements, and modern communication and educational technology. Above all, they will demand new professional attitudes and orientations.

There will need to be a major shift in the emphasis of undergraduate medical education from its current specialist orientation based on hospital medicine to a primary, generalist orientation strongly based on the practice of primary care in the community. Students will need to be trained in the skills of (i) educating the public so as to stimulate community self-reliance and the exercise of responsibility in protecting health; (ii) multidisciplinary and multisectoral teamwork; (iii) extending health care coverage to underserved, vulnerable, and deprived families and groups; and (iv) associating themselves as health professionals with action that the community takes to identify and deal with the primary causes of ill health and to reduce the effects of chronic disease and disability.

In every country, the reorientation of medical education to the requirements of the regional strategy for health for all can be undertaken only when the government establishes a corresponding national strategy. This would normally imply government support - including the allocation of funds in favour of the primary care level of the health services - in overcoming the obstacles that exist to the reorientation of medical education towards primary care. At that point, medical schools would have not only an obligation to adapt to national health policy requirements but also an opportunity to provide a lead in putting into practice the concepts of primary health care as a basis for reorienting and organizing their educational programmes.

OBSTACLES TO REORIENTING MEDICAL EDUCATION TO PRIMARY HEALTH CARE

The seminar identified two groups of obstacles to reorienting medical education towards primary health care. The first group are those that impede change in medical education generally, and the second are those that prevent the full range of primary health care from being given its due place in the medical curriculum.

Confusion about the objectives of undergraduate medical education

National authorities are not specific about the competencies to be expected from undergraduate medical education. A number of countries and organizations are insisting on the need for postgraduate training in general medical practice before graduates can undertake independent practice. If this practice were generally followed it would absolve medical schools from the responsibility to train their students to be competent primary care practitioners, and allow them to neglect primary care in the undergraduate curriculum because of an often hypothetical provision for postgraduate education. Yet in most countries the undergraduate curriculum is sufficiently long (six to eight years, for example) to allow students to graduate as competent primary care practitioners.

It may be very difficult in some countries to obtain from the body that controls the registration or licensing of medical graduates a formal statement of the primary health care competencies expected of new graduates. Often the undergraduate course is considered only as a basis for undertaking postgraduate education, usually for a specialty. How this policy of producing an undifferentiated doctor accords with the WHO regional strategy merits study. It may be related to policy on hospital specialist provision: if a health service is a highly medically specialized one, oriented to high technology, and at the same time specialists determine or strongly influence policy regarding medical education, it would follow that undergraduate education and internship training would not be expected to equip students with the competencies they would need for primary medical care, far less the wider range of competencies demanded by primary health care. Besides, specialists, who strongly influence medical education, are not aware of the potential of primary medical care, and do not advocate or support the kinds of curricular reform which would produce competent practitioners of primary medical care, and even result in a more efficient use of specialist services. One dimension of this problem in many countries is the practical exclusion from medical studies of candidates with secondary education in the human and social sciences

in favour of those whose academic background is in the biological and physical sciences and who are therefore more likely to choose specialist medical careers.

Poor communication between medical schools and health authorities

Medical schools can be faulted for poor communication with government, for not seeking partnership with government, or for pursuing individual interests in teaching and research. Health services research in particular, which all governmental bodies with responsibility for health services need, is poorly represented in medical schools compared with traditional biomedical research. Governments and health authorities in general need to have access to, and the cooperation of, the research and training facilities of medical and other university faculties in order to give practical effect to the concepts of primary health care.

Isolation of medical schools from communities

The skills that doctors will need for the practice of primary health care, like any other form of health care practice, cannot be learned other than by means of a carefully planned series of practical learning experiences based on a representative range of health problems and in the setting in which these problems arise and are normally dealt with. This learning will need to be continued throughout the undergraduate course so that students will have attained the requisite level of competency by the time they graduate.

This will need, besides an extended range of educational skills and practices, the introduction or extension of the use of extramural, extra-hospital, community services (not only health care services) for teaching/learning purposes, for a substantial part of the medical curriculum. Yet many countries have no tradition of such use. In some countries, medical schools are obliged to admit very large numbers of students, and a highly community oriented curriculum would impose considerable logistic difficulties on these schools. This obstacle will reinforce the position of medical faculties

that favour passive, classroom methods of instruction over the active, competency-based learning that primary health care will call for.

Departmentalism in medical education

One of the principal obstacles is the great predominance of departmental, subject centred curricula based on, and oriented towards, specialist, high technology medicine. Commitment to primary health care as the main objective of medical education will require competency based, problem solving, generalist oriented curricula. (Competency in this context includes a broad range of knowledge, attitudes, and observable behavioural patterns which together account for the ability to perform a specified professional task) (1). It is extremely difficult to introduce competency based learning into a departmentally organized, subject centred curriculum with required conventional courses and examinations. Medical faculties in general lack the educational management skills for doing so, and are unaware of or uninterested in the disadvantages of departmentalism and the advantages of competency based curricula. Besides, there are powerful vested interests in favour of preserving the departmental structure of curricula.

Poor representation of basic sciences for community health

Another obstacle is the marginal contribution that some "non-medical" sciences, which may be considered basic sciences for community health, make to education for primary health care (e.g., environmental sciences, education, political science, sociology, anthropology, health economics). Related to this is the low priority accorded in medical curricula to the prevention of disease and the promotion of health.

Difficulties in integrating non-clinical parts of primary health care with predominant forms of practice

The obstacles to representing primary health care adequately in the medical curriculum include those that impede it from becoming an integral part of a country's health system and thus a framework or basis for student learning. Even where primary medical care is already well established in a country's health services and even a

curricular subject with its own component of practical training, there will be particular difficulties associated with the integration into primary care practice of the largely non-clinical components of primary health care. Thus community participation, with self-care, is inconsistent with the patterns of conventional health services and the predominant attitudes of health professionals; there is little or no precedent for multisectoral cooperation in regard to the management and control of health problems; and the extension of coverage to underserved and at-risk groups will demand unusual forms of medical care delivery by which health professionals take the service to such groups rather than wait for them to approach a service. A medical school cannot train students to be competent in primary health care unless its different elements are represented in the community services in which students are trained.

Excessive medicalization of health care and uneven quality of medical care

Excessive or unbalanced medicalization of health care, or health care that depends unduly on pharmacotherapy and "high" medical technology, is an obstacle to primary health care. It is reflected in the current structure and patterns of primary care and medical education (the lack of provision for practice and training in multidisciplinary teamwork in primary care, for example) and in the expectations of the general public, and reinforced by the mainly clinical and specialist interests of influential health professionals and medical educators; the predominant health problems of the European Region are not significantly affected by medical care and drug treatment alone.

The quality of primary medical care is very uneven. There is evidence of great variability even within countries in the extent to which communities are obtaining the potential benefits of medical science. Neither the public nor many practitioners are aware that there is often a wide gap between what is technically feasible and what is actually being received. Consequently, primary medical care is often less valued than it might be by both health professionals and the public. If students are to be attracted to, and well trained in, primary medical care, they should experience primary care of consistently

high quality, which inter alia uses modern technology and specialist services efficiently and with discrimination for the communities it serves.

Lack of intersectoral cooperation and coordination for health purposes

An obstacle to be overcome at government level is the general lack of any tradition of cooperation between, or of coordination of the policies of, the health sector and other public sectors. This is reflected, with regard to the medical school, in inadequate communication and cooperation between the health authorities, which are responsible for health care services, and the medical schools, which educate the medical manpower for the services; it reflects and reinforces negative attitudes of government health departments and medical schools towards each other, and makes it difficult to integrate local educational facilities with health services.

At a higher level the lack of intersectoral coordination is reflected in the reluctance or inability of governments to take effective action on the control of the industrial and commercial enterprises whose products are associated with the predominant diseases and disabilities of the WHO European Region. This inconsistency with a multisectoral approach to the primary prevention of disease and disability is one of the reasons for the view that many governments may not be committed to primary health care to the extent that industrial, commercial and fiscal interests would be seriously affected, and that they may expect of medical education only a watered-down version of primary health care.

Political, professional and commercial resistances to primary health care

Another obstacle or group of obstacles arises from the political implications of primary health care. It implies in countries with strong centralist governments a dilution of central government authority, with peripheral sectors making decisions - which are often political - on health matters. Also, it calls for a redistribution of power as between the health care professions and the people. It is likely, therefore, to encounter formidable professional and ideological resistances which could have the effect of

reducing efforts at education (and practice) in primary health care to merely "cosmetic" changes. Calling primary medical care "primary health care" may be one way of adopting primary health care without disturbing the status quo.

Commercial technological interests also may resist what they may consider a threat to high technology medicine. A pattern of high technology medical practice with its associated specialist educational patterns may well show a certain lack of enthusiasm for primary health care. Planning primary health care education, in some countries at least, will have to take account of such obstacles.

Failure of governments to communicate the primary health care message

Five years after the Alma-Ata Conference, few governments have informed medical schools or other health care educational institutions, or the public, of the commitment they have made to the goal of health for all and to primary health care as the key approach to this goal. As a result, those medical educators who have become aware of the primary health care movement have a very imperfect appreciation of the nature of primary health care and of the demands it will make on education and research (2). There is a widespread practice, reflected in the medical literature and in statements of official bodies, of equating primary health care with primary medical care or general practice, and a tendency to dismiss primary health care in its Alma-Ata sense as "unrealistic" or "meant for developing countries where there is a shortage of doctors".

In most countries of the Region no national body has been set up to promote the concept of primary health care or to identify and publicize local primary health care initiatives.

Lack of involvement of nongovernmental organizations in promoting primary health care

International nongovernmental organizations in association with WHO have, in general, not transmitted information about primary health care and the regional strategy for health for all to their national member organizations.

Professional associations of the various practitioners and therapists with primary care responsibilities at regional and local levels within countries are generally unaware of health care developments in the international sphere. WHO publications and other documents rarely come to the notice of national and local groups of health professionals. Moreover, readers who are not concerned with international health policy-making, and whose frames of reference do not comprehend cultures and conditions that are very different from their own, find the language of WHO publications and documents on primary health care difficult to understand.

OVERCOMING THE OBSTACLES

In identifying and specifying the conditions needed to permit the full range of primary health care to be represented in medical curricula, not all the seminar participants were optimistic about the prospects of overcoming many of the obstacles they had identified to assuring these conditions. They considered it very important that those who will be responsible for guiding the necessary reorientation should not underestimate these difficulties. In particular, they considered that the new primary health care components of health care must be soundly based on research and evaluation, and that both health professionals and the public should be satisfied that they can lead to worthwhile health results. The regional strategy document is a normative statement which has to be made operational by means of research and the evaluation of experience. Such research and evaluation will need to be university-wide activities and not only biomedical, but will be inseparable from the training of professionals for primary health care.

In considering possible ways of reorienting medical education towards primary health care, due note must be taken of the diversity of conditions in the countries of the European Region and the necessarily diverse approaches to primary health care in medical education that will be indicated when countries draw up their national strategies for health for all.

In some countries a gradual extension of existing primary care services and of education in primary medical care is likely to be a more effective approach to the reorientation of medical education than an attempt to make

radical changes in a short time. Such an approach would incorporate missing, or expand under-represented, elements of primary health care (referred to in the seminar as "limited opportunism"), with adjustments of resource allocations as between primary health care and specialist care. In other countries, however, it would be unrealistic to think that medical schools could make any worthwhile contribution to primary health care without radical and extensive reforms of both services and education. In countries with few or no primary care services, especially outside large cities, or with uneq al distribution of doctors, it is clear that new legislation and other government action will be needed, with fundamental changes in health services planning and management, to assure an even distribution of primary care services. Correspondingly radical changes will be needed in the education of health professions. In such circumstances, where a "critical mass" for an evolutionary approach is lacking, radical - even revolutionary - action may be needed.

In either case - whether evolution or revolution - certain conditions will have to be provided, and certain criteria set, to enable the necessary changes to be put into effect and to guide their development.

CONDITIONS NECESSARY TO REORIENT MEDICAL EDUCATION TO PRIMARY HEALTH CARE

The conditions to be met will depend in part upon the national health strategy which a country adopts and upon the nature and pattern of the primary health care component of its health system, and in part upon the learning needs of students. However, a number of conditions appear to be generally applicable.

Government commitment

In the first place, governments will need not only to express their commitment to health for all and to primary health care, as they have implied by their adoption of the regional strategy, but also to allocate to primary health care the resources it needs if it is to become, in the words of the Alma-Ata Declaration, "the central function and main focus" of the health system.

Manpower planning

National health plans and strategies should provide a basis for manpower planning; for determining, for instance, what proportion of medical manpower will be needed for primary care as distinct from secondary and tertiary care, and what their roles and functions will be in relation to those of non-medical manpower categories. Decisions will then be needed on the numbers of students to be admitted to medical schools and on possible changes in entry requirements to produce a better balance between students with a major background in the biological and physical sciences, on the one hand, and those who have favoured the human and social sciences, on the other. These decisions should take account of the resources that can be provided and developed to ensure an acceptable quality of education and training, particularly for primary health care and for the new competencies that medical graduates will need for primary health care.

Support from medical schools

Before universities and medical schools can come into play in support of primary health care and the strategy for attaining health for all in any country, they must be adequately informed of the government's intentions, and their support must be solicited in working out the national strategy and its manpower implications and consequences. The lead being given by WHO in this respect internationally could be taken up nationally by a body responsible for promoting primary health care in its full sense; the membership and terms of reference of such a body would need careful consideration to ensure its representativeness, authority, and effectiveness. It could serve, among other purposes, the catalytic function of interesting universities as a whole as well as their health science faculties in collaborating in attaining a country's health goals. It would do so mainly by making available to them the results of operational research into the functioning of primary health care services, and of evaluation of primary health care experiments, and by commissioning special studies designed to identify as objectively as possible what would be feasible and worthwhile in their particular settings.

Informed decision-makers

Politicians and officials must be made aware of the nature and scope of primary health care and of its potential for promoting health and general socioeconomic development. This should be done not by exhortation but rather by keeping them informed of proven progress and shortcomings, and of research carried out or in progress. The application in practice and in education of the concepts of primary health care must be guided by research and evaluation. The results of research and evaluation must be publicized in language that can be generally understood. A Swedish medical faculty which receives funds specifically for research in primary health care promotes understanding of the concepts and approach of primary health care by organizing "research information days" for politicians. Even within medical faculties an effort must be made to make the "language" of community oriented medicine comprehensible to clinical specialists.

Educational planning

Skilful educational programme planning will be needed to translate health service needs into the objectives and organization of educational programmes. This will be a responsibility of whole schools, not only of primary care and other community oriented departments. The objectives of the whole undergraduate curriculum, in terms of the primary health care competencies which graduates will be expected to demonstrate, must be clear and unequivocal. There must also be provision for reviewing and modifying them in the light of educational and health programme evaluation and of educational and health services research.

Since primary health care is essentially multidisciplinary and multisectoral, these elements will need to be represented in educational planning and in the learning settings, particularly as regards practical training in the community. Research at this level needs a similar orientation.

Evaluation procedures

In respect of educational planning, if medical schools are to reorient themselves towards primary health care in support of national strategies for health for all, they

will need to cooperate closely with health administrations and professional associations, particularly in two related areas: the definition of competencies for curricular purposes, and the evaluation of educational programmes. If evaluation is competency-based and evaluation criteria are derived from actual practice, this could be a means of ensuring the relevance of educational programmes to practice and to community needs. As regards the evaluation of educational programmes, medical schools need to give particular attention to the validation of procedures for assessing students, against agreed standards of performance of primary health care functions. By cooperation in the definition of competencies and in evaluation, medical schools can guide change rather than follow it and play an important part in determining the methods, developing a technology, and avoiding rigid models of primary health care.

To determine the educational objectives of curricula oriented towards primary health care, each country will need to lay down the range and the level of competency which will be required of the graduating physician. At present in most European countries medical schools are not specific in this respect. Certifying or licensing authorities confer the licence to practise medicine at the end of a pre-registration internship period, thus implying or guaranteeing "competency", without specifying its range or limits. Once it is decided that a medical school, or a country's undergraduate medical education system, is to be reoriented to primary health care, as implied in the regional strategy, it will be essential to specify the generic skills and the primary health care skills which students will be expected to acquire from the basic curriculum. Although there is yet no reported experience in training students for the wider range of skills demanded by primary health care, as compared with primary medical care, there is no firm ground for claiming that undergraduate curricula - sometimes six, seven or eight years in length - could not produce competent primary health care practitioners if this became an agreed institutional objective and the time and other resources were effectively applied to this purpose.

However, in some countries it is claimed that undergraduate medical education cannot result in a medical practitioner capable of practising independently, and that

its purpose must, rather, be to provide an adequate foundation for any type of medical career, to be followed by postgraduate training. In several European countries, governments or registration bodies have formally denied the competency of graduates to practise independently after completing only the undergraduate curriculum. At least three countries have adopted legislation requiring doctors who intend to practise primary medical care independently to take postgraduate training, and a draft directive of the European Communities, supported by the European Organization of General Medical Practitioners, advocates a two-year period of postgraduate training for all primary medical practitioners.

On the other hand, as seminar participants pointed out, competency for primary health care cannot, in general, be left to postgraduate education or vocational training, or to continuing education, because few countries are in a position, at least in the medium term, to provide or assure adequate facilities and conditions for this purpose. Apart from the responsibility of medical schools to train students in the basic primary health care competencies, there is another good reason for the subject to be strongly represented in undergraduate education: to allow students to acquire their concepts of medicine and of health at a stage when they are not yet strongly identified with specialist medicine and have not acquired defence mechanisms against anxiety, sickness and death. In addition, the undergraduate experience may be the only opportunity for those who will later become clinical hospital specialists and senior teachers of their disciplines to obtain an understanding of the nature and scope of health derangements and health care at the primary level.

The seminar did not resolve the issue of whether it should be an objective of the undergraduate curriculum to produce a competent primary care practitioner. It was, in general, considered to be a policy issue, for national authorities to determine; if they decide that undergraduate medical education is to be reoriented towards primary health care, educational strategies can be devised to produce competent primary health care practitioners at graduation or registration, and to maintain competency afterwards. This was seen as a matter of reorganizing the curriculum rather than prolonging it.

Legislation

Legislative changes may be needed to modify regulations which govern the professional relationships between medical and non-medical members of primary health care teams, and to remove certain restrictions on the professional role of nurses, for example.

THE COMMUNITY AS THE TRAINING SETTING FOR PRIMARY HEALTH CARE

Organizing a primary health care training community

Since the medical care component of primary health care is generalist medicine practised mainly in the community, it follows that the central and most important setting for education and training in primary health care should be the community. Students should be trained in the context of the community's health and other public and voluntary services, its exposure to the pressures that produce and maintain unhealthy lifestyles, its social and physical environmental deterrents to health, and its positive forces which can be applied to promoting health. The primary health care system used for training purposes should satisfy the criteria laid down in item 20 of the regional strategy; that is, it should:

- be built on the principle of community participation;
- be staffed by a multidisciplinary team;
- serve as first point of contact to the national health system;
- be supported by an effective referral system;
- prevent disease, promote health, care and rehabilitate;
- maintain a continuity of relationship with every member of the population it serves;
- reach out into all homes and workplaces systematically to identify those at highest risk;

- help people to assume greater responsibility for their own health.

It will be a joint responsibility of the health services of the training community, the medical school, and the educational institutions for the other primary health care professions to develop these elements into active components of the community's health care services, suitable also for training and research purposes. This would bring health teams, and consequently medical students, into relations with professionals from other sectors concerned with such health related activities as social welfare, urban planning, rural development, housing, schools and policing, and with industry, leisure facilities and mass communication media, to promote health and prevent disease and disability, and to support community self-reliance in health matters.

Formal relationship between universities and communities

As far as possible, communities used for training purposes should demonstrate joint planning and administration of health care services and of educational programmes for health professionals. Formal arrangements will need to be made for this purpose, and formal relationships established with communities and their services to permit and regulate the education, research and service activities of medical and nursing schools, and other university disciplines, in the framework of the community's health and other public and voluntary services.

Since the regional strategy is concerned mainly with the prevention of disease and the promotion and protection of health, the community services in which students are trained should be primarily and explicitly geared to these functions. It is in this context that primary health care teams to which students would be attached would guide and support community and multisectoral action. The primary health care service should be structured in such a way that it leads the community and its families to take initiatives with regard to protecting or promoting their health, and that they take an active part in the process of making community diagnoses of health status and health problems. It will be a function of the primary health care team to help them to select indicators of positive health and units of measurement of health status, to make

explicit their needs or demands, to define their priorities, to plan and implement their programmes, and to evaluate the outcome. The medical and other health care students should be given specific learning roles in all such community and multisectoral activities. Some could take part in research in the community as a means of "learning" primary health care. At the same time, the primary health care training setting must maintain agreed high standards of primary medical care.

It is by building these various components of primary health care into the community training setting and into everyday practice that they can become real components of the medical curriculum rather than merely theoretical concepts.

The size of the training community

Since medical, as well as nursing, curricula oriented towards primary health care will be concerned with training in a much wider and more intensive range of competencies than even the most progressive schools are at present, students will need long and repeated periods of attachments to communities and their training facilities. In keeping with the principles of problem-solving and competency-based curricula, practical training in the community will need to begin on entry to the medical school and to continue throughout the curriculum. Large numbers of students will therefore be in training at any time. The same communities and facilities will be meeting the needs of other primary health care students, as well as the research, training and service needs of other university faculties concerned with socioeconomic development and health promotion. Large population groups will be needed, therefore, which should be demographically and socioeconomically representative, with their primary health care practitioners who will take part in the training and supervision of students - the doctors, nurses, social workers, therapists of various kinds, sanitarians, administrators, and non-health sector professionals - and the various health care, social welfare, educational, religious, and other health related institutions and organizations.

The model of the regional health university: its advantages and disadvantages

A recent model for integrating health care and education of health professionals is that of the regional health university, a university of health sciences in which all the health care professions are educated and the health care system of a regica of a country provides the basis for training and research (3). It facilitates interdisciplinary education and training. It is a particularly suitable arrangement for research into the operation of health services and of multidisciplinary teams. In principle, it should facilitate community participation and multisectoral cooperation in promoting and protecting health. However, its advantages from bringing together the conventional health sciences in one institution must be weighed against the risk of isolating and separating them from the human and social sciences, and from the group of basic biological disciplines, whose potential contributions to primary health care need to be harnessed to the health disciplines. Also, it is not clear that existing models of such institutions can incorporate the roles of the community and of non-health sectors in primary health care. Moreover, the management of the educational programmes of diverse categories of health care students demands educational skills that are in short supply.

The report of a Swedish commission (4) which has advocated a regional health university (RHU) refers to the need to find forms of university structure and administration "that will allow the greatest possible coordination between the various bodies responsible for health care and education, respectively". It goes on:

> Taking the concept of health as the starting-point, the education programmes of the RHU must be characterized by, among other things, the following:
>
> an extended concept of health as the starting-point
>
> orientation towards preventive measures
>
> epidemiological awareness

training in those qualities that facilitate an overall assessment of health and disease in the individual.

From the viewpoint of the concept of the region the following must characterize RHU education programmes:

close cooperation with health care in surveying and analyzing the health problems of the region

active participation in the preventive health care and health information activities in the region

they must be rooted in the primary health care organization.

From the viewpoint of the concept of the university, RHU education programmes should be characterized by:

joint planning and administration of education in close cooperation with the regional health care system

links between the education programmes and every kind of research within the framework of the RHU

integration of the various education programmes based on the roles of the different professional groups within the health care system.

Developing and supporting community health staff as training resources

In keeping with the primary health care dictum that the best use must be made of available resources, the large number of trainers and supervisors needed in the community to ensure adequate standards of training and supervision will have to be drawn mainly from the medical and other health care staff of the community services. The medical and other schools concerned will need to be in a position to assure the quality of training and supervision in the community. There should be incentives for retaining a core of competent trainers/supervisors and helping them to develop in their educational roles.

Much as it is desirable that all teachers of primary health care be model practitioners and model teachers at the same time, health professional schools for all manpower categories concerned with primary health care will have to depend at first on the practitioners and other professionals who are available and enthusiastic or willing to cooperate. For the beginning, at least, even poor quality practice may have to be used for teaching purposes: the value of negative examples should not be overlooked - student criticism can be an important element in educational development. It will be the task of those responsible in the medical school for primary health care to enable the teachers and supervisors of medical students in the community to play their educational and supervisory roles and to provide them with opportunities to develop the requisite skills as well as to maintain a high quality of practice. The result of such support should be evidence, documented by suitable evaluation methods, that the planned learning takes place (going beyond evidence that stimulating impressions are being collected). The need to develop and use valid evaluation instruments for this purpose is paramount. The methods of evaluation applied, for formative and summative purposes (such as chart audit, observational studies, or structured interviews) must be adapted to the specific nature of primary health care if valid and reliable data are to be obtained on the learning process and its consequences for the students, practitioners, patients, families and groups concerned.

The medical school must guard against imposing prohibitive administrative and financial burdens on practitioners and peripheral institutions, or relying on the initial enthusiasm and motivation often manifest when "outsiders" are first asked to take part in teaching but are later left to struggle with problems beyond their means of solution. While the medical and other health sciences schools have primary responsibility for all the supportive measures of a decentralized educational subsystem, the cooperation of professional organizations can be very significant.

Criteria of acceptability of training resources in the community

Those responsible in the university and medical school and in government will need to devise criteria of acceptability for training purposes with regard to facilities, services and other factors, and to have the authority to impose standards or withdraw recognition of unacceptable facilities. The criteria of acceptability should take account inter alia of the conditions in which students will later practise; the training conditions should be reproducible within the usual budgetary limitations imposed in the country.

ORIENTING THE MEDICAL SCHOOL AS A WHOLE TOWARDS PRIMARY HEALTH CARE

While it would be impossible to forecast or indicate the various ways in which medical schools might reorient themselves as total entities towards primary health care, the seminar identified three groups within the medical school, the joint efforts of which could do much to ensure success in adapting curricula to primary health care, viz. the clinical and paraclinical departments, the so-called "minority" or community oriented disciplines, and - where it exists - the educational development and management group.

The potential of specialist clinical and paraclinical departments

The specialist clinical and paraclinical departments and disciplines of medical schools can contribute very significantly to education and training in primary health care. The ways in which they would do so have hardly begun to be explored, but they call for imaginative educational initiatives and openness on the part of the primary care "bloc" as well as of the other departments. Ministries of health and medical educators responsible for primary health care cannot afford to neglect to seek and continuously foster the cooperation of these departments.

Although resistance on the part of the specialist departments to the introduction or expansion of primary health care in medical curricula is inevitable and could easily be underrated, it is far from being monolithic or

completely unopen to change. Clinical departments of medical schools might be ready to review, over a semester or an academic year, their teaching programmes and evaluation instruments against criteria of suitability for primary health care. There is no reason why the results of such a review should detract from the importance of their subjects as major disciplines or be considered as "interference from outside", since there can be no inconsistency between high quality clinical competency (as distinct from unduly sophisticated technology) and primary health care. Often what is needed is a change in emphasis from the explicitly specialist elements of a special field of medicine to its generalist or primary care aspects. The patients whom the students see in the teaching hospital are not representative of primary medical care: they represent the 5% of patients whom general practitioners in those countries with distinct primary care services refer to specialists. Many specialist teachers are likely to be ready to try to reflect this reality in their teaching, but it will call for systematic study of the problem rather than on-the-spot individual judgement of what is specialist and what is generalist. It can hardly be resolved unless the specialists do a certain proportion of their teaching in generalist or primary care facilities. In this way the issue of the differential allocation of time and other resources as between hospital specialist and community generalist medicine may be defused. Experiences in this kind of cooperation should be publicized. Care must be taken to avoid the transfer of specialist technology and teaching practices from the hospital to the primary health care setting in the guise of community health care services and to the exclusion or dilution of genuine primary health care technology.

The contribution of the community oriented disciplines

The various medical and nursing disciplines concerned with the community - the so-called "minority" disciplines such as social and occupational medicine, epidemiology, general practice, geriatrics and long-term care, and social psychiatry - could join forces to form a strong community oriented sector of the medical school linked to primary health care for purposes of research, education and service. However, this should not have the effect of polarizing the clinical and the community dimensions of

medical education since, as has been seen, the former have essential contributions to make to training for the medical components of primary health care. A balance must be struck between the specialist and the primary care dimensions that recognizes their complementarity but reflects the reality that by far the greater part of health care is provided outside hospitals, mainly by doctors and nurses; and that prevention and health promotion are, essentially, community based, depending largely on community participation and multisectoral cooperation.

A role for educational development groups

Increasingly, in progressive medical schools, there are educational development and management sections or groups, with varying degrees and dimensions of educational expertise. They could be of assistance to medical curriculum committees concerned with reducing "departmentalism" in medical education in favour of competency based, problem solving curricula, although it must be acknowledged that curriculum committees have experienced great difficulty in reducing departmentalism. The elements of community participation and multisectoral cooperation, the needs of vulnerable and underserved groups, and multidisciplinary teamwork in primary health care could be represented in the composition of curriculum committees. Student representatives on curriculum committees tend to be educationally progressive, and care should be taken to ensure that their role be real rather than merely "cosmetic". Medical faculty teachers (not only those concerned directly with primary care and community health) could be oriented towards primary health care, especially by soliciting their cooperation in modifying the curriculum and by inviting or persuading senior clinical and other professors to take part in training for primary health care, not only in the clinical departments but also in community facilities. Teachers responsible for primary health care, including medical, nursing and other primary care practitioners with responsibilities for teaching and supervising students, could be trained in methods of managing problem solving, competency based learning in community settings.

The cultivation of this kind of joint action and collaboration of "power groups" within a faculty should be consistently fostered as an educational management strategy in teaching institutions and countries, and as a responsibility of primary health care educational leadership. The harnessing of the potential of these three groups could be reinforced by the generally positive attitudes of medical students towards relevant and practical educational programmes. The support of professional organizations in this respect can be very valuable.

Associating the medical faculty with other university faculties

Outside the medical faculty, university governing bodies and the non-health faculties constitute potentially powerful allies with whom the primary health care group in the medical school can cooperate. Since health cannot be attained by the health sector alone, the potential of the university (of the tertiary education system in general), as distinct from its medical or other health sciences faculties, needs to be explored and realized. In this regard the seminar participants had before them the report of a recent WHO Consultation on Mobilizing Universities for Health for All, which indicates the broad front of public sectors and university (or tertiary education) faculties and disciplines with which medical faculties could be associated in the context of primary health care. This kind of involvement of the university in community services accords well with the modern concept of university autonomy which "implies more the positive ability to be an effective partner with areas of the community than the negative defence of a set of freedoms" (5).

The mobilizing of universities for health for all and primary health care could, as one effect, strengthen the primary care/community oriented elements of medical schools and consequently lead to a better appreciation on the part of traditional medical faculties of the need for change. Governments and primary health care educators could develop alliances at the level of the university government board as well as at faculty level (e.g. economics, psychology, sociology, anthropology, geography, political science, bioengineering,

architecture, urban planning); and university funds might be utilized for cooperative inter-faculty projects in research and education.

Safeguarding the specificity of primary health care in the medical curriculum

If primary health care becomes "the central function and main focus" of a country's health system (Alma-Ata Declaration) it should have a correspondingly central place in the medical curriculum. The implementation of the regional strategy for health for all depends on support and contributions in teaching, research and service from the whole of the medical school, and on striking new organizational balances within the school, and between the school and the health services. It is in this way a responsibility of the whole school. However, the specificity of primary health care as a form of health care practised by generalists, and as a discipline or a separate entity in the medical curriculum, must be respected and safeguarded in the structure, organization and management of the curriculum. Otherwise this specificity risks being lost, together with the opportunity to transmit the generalist's perspective and insights to the next generation of doctors. The generalist or primary health care practitioner, whether doctor, nurse or other therapist, as the first point of contact with the health service, must exercise special skills in primary assessment of presenting problems, however minor they may be. People often approach primary care services for reasons other than disease. It is a function of the generalist to recognize and understand the attitudes, feelings and perceptions of health and illness of the patient; to appreciate the importance of the family group and how incidents within the family affect its individual members and their patterns of use and seeking of health services; to work in the home regularly and to use the insights gained from working in the home in care and in helping the family to take responsibility for its own health; and to provide and coordinate long-term care.

In this connection it is of interest that other professions, e.g. law and engineering, are concerned about the generalist/specialist issue in education, and are studying the implications of concepts of generalism for

professional education. There are, therefore, forces in higher education which would strongly support generalism in medical education.

Primary health care in the academic structure of the medical school

The generalist or holistic perspective has to be represented in the organization and the power structure of the medical school and in the planning and management of the curriculum, and not in any merely symbolic or superficial way. Its elements have to be represented in the students' learning settings and learning materials; sufficient time has to be made available to cultivate it; and clinical specialist teachers have to be able to distinguish between the generalist and the specialist elements of their disciplines so as to respect the primary care orientation of the undergraduate curriculum. It has to be expressed, therefore, in clearly formulated and elaborated institutional objectives and skilled educational management rather than as a conventional academic package with an anti-specialist bias.

It seems to be important for educational purposes in some countries to determine whether primary health care should be considered a specialty. (This issue may be related to an unduly narrow view of the scope of primary health care - which equates it with primary medical care, for instance.) Primary health care has components such as primary medical care or primary nursing care or other therapies, each of which has its own specificity and a claim to specialty status according to the different conditions and systems of different countries. Other essential components of primary health care cannot be regarded as medical specialties because they are not medical. However, there is no argument about the academic or scientific basis of primary health care; it comprehends or draws on a range of sciences which are already established or being established in the education and research activities of the more progressive medical schools; as the key approach to the goal of health for all it will need to encompass academic disciplines which are not yet generally included in the health care disciplines. In the academic context it must be able to meet standards of academic excellence which are as rigorous as those of the conventional specialist subjects

in undergraduate curricula; those who profess it should not feel bound by arbitrary conventional notions of what constitutes academic excellence.

With regard to the research basis of primary health care, new developments in health research carry much promise of applicability in generalist health care, research which spans the specific subcultures of science labelled as biological, behavioural and social. The generalist much more than the specialist cares for patients in a context in which the bio-organism, the psyche, and society are associated with one another. The range of research, therefore, is correspondingly wider than that of medical research as commonly envisaged.

The seminar considered how primary health care and the generalist perspective might best be incorporated in the academic structure and organization of a medical school. Some participants strongly advocated the creation of a chair - or of several chairs of component subjects - of primary health care. Others expressed scepticism about copying or following conventional academic political tactics, and of perpetuating existing and outmoded structures, for new educational purposes.

The establishment of a chair and department of primary health care in a traditionally structured medical school might or might not have a significant impact on the competence and orientation of physicians. It will often be necessary as a medico-political tactic in order to establish and develop the academic discipline of primary care. However, in the context of the fundamental reorientation of medical education called for by the regional strategy, its establishment should not result merely in primary care being introduced as an academic subject among many others, restricted to its own circumscribed departmental course, and thus absolving the rest of the medical school from responsibility for reviewing and modifying the entire curriculum. Some formal organizational structure will be necessary in order to obtain entitlement to funds and premises, and to satisfy administrative requirements.

It will be important for purposes of education, research, and service in the community to avoid stereotyped academic conventions if they place

unacceptable constraints on necessary curricular innovations. Those specifically responsible for primary health care in the medical school, however they are organized or designated, must be free to discover, from research and experiments, ways of applying both the time-tested generalist concepts and the primary health care concepts that are new to health care, and to concentrate on attaining well defined educational objectives by means of carefully selected, proven methods of teaching, learning and evaluation. Concern about core curricula (in the sense of core content), for example, should be replaced by concern about core objectives (in the sense of core competencies which students must acquire) and the variety of ways in which they may be achieved. Whatever the organizational arrangement may be, it should permit a wide and flexible scope of action, multidisciplinary and multisectoral, partly within the school and university but largely outside its walls; it should permit also the association with the school for education and research purposes of many external resource people from both health and non-health sectors, providing or associated with primary health care services. Much of this may be accomplished without formal chairs of primary health care or a specific departmental budget but rather by using imaginatively, and with a range of educational management skills, the elements of primary care, community medicine and public health already existing in many schools and in the health and social services.

In some places, new departmental structures in the medical school may well be a necessary means of creating a "critical mass" of faculty staff, which would include, for example, behavioural scientists concerned with the psychology and the sociology of health. In other places, the means used might be collaboration of medical and other university faculties. If, for whatever reasons, a department and chair must be established, it becomes a matter of skilful educational management to overcome or reduce the barriers to sound curricular development inherent in a departmentally organized curriculum.

It is unlikely, in general, that large independent departments will be established to provide a focus and educational leadership for primary health care. What is more realistic to aim for is that an existing department - of general practice, community medicine or epidemiology,

for instance - would assume the role of catalyst in this regard, stimulating and cooperating with various other departments and disciplines of the medical school and the university to play their special parts in primary health care and ensuring that their contributions in teaching, research and service are valid and genuine. Such an integrated programme, drawing on resources from across the structure of the medical faculty and the students in other university faculties, and from the other related health care disciplines and services (but also with its own specific field of competency) might be made the responsibility of an organization within the school headed by an assistant dean.

Allocation of curricular time to primary health care

In a departmentally organized, subject centred curriculum, time allocated to departments is regarded as of crucial importance. In a competency based curriculum the issue of the proportion of time to be devoted to mastering a group of competencies, e.g. primary health care, is secondary or incidental to such issues as the range and levels of competencies which the school undertakes to impart, the quality of educational programme planning and management, the scope and nature of evaluation, and the demands made on medical graduates in the health care services. Time allocated by, or wrested from, curriculum committees without reference to the characteristics of the product of the curriculum may be as badly used in primary health care as in other parts of the curriculum. Nevertheless, if it becomes policy that in order to graduate students must demonstrate a block of primary health care competencies as one block among several, and if the medical curriculum is run on a time-subject rather than on a competency basis, the amount of time needed for students to master these competencies at the requisite level will need to be formally allocated to primary health care.

The physical facilities for primary health care in the medical school

Whether a chair and professorial unit for primary health care is established or another arrangement is made, it would be logical to situate its main premises in a central part of the training community, preferably in an underserved area where the predominant health and related

social problems occur. The facilities should be designed primarily to enable the educational programme to be managed. Thus the specifications should provide for regular meetings of a primary health care curriculum committee with the requisite academic, educational, student, and various consumer interests represented, and for consultations and group learning activities with non-health sectors, voluntary organizations and other community groups. The facilities should reflect also the multidisciplinary nature of primary health care since health-care disciplines other than medicine will have crucial contributions to make to the planning, implementation, and evaluation of medical education. The facilities should provide for the needs of group learning and individual study, and for students to manage their own learning activities in the community. The needs of students who take electives or undertake special studies in primary health care must be considered. The learning resources should include the equipment and the learning materials for mastering the elements of communicational, informational, statistical and educational technology for the different disciplines represented in primary health care teams. The needs of continuing or postgraduate education for primary health care must be considered. Student residential accommodation must be provided. From the variety of functions to be served, it may be seen that an architecture of primary health care education and training facilities is needed, which should differ radically from conventional medical school and health centre design concepts.

Training university teachers for primary health care

The functions of the medical school professors and other teachers and educational resource staff responsible for the curricular and research aspects of primary health care will need to be defined in some detail and in terms of the management of a relatively complicated, decentralized, community based educational programme. The university teacher in the role of manager of such a programme will need skills which are quite different from those needed for classroom and clinical instruction. They will include the ability to work with a primary health care curriculum committee in which all the concerned disciplines and interests are represented: primary health care practitioners and administrators, communities, non-health

sectors, underserved and vulnerable groups (the handicapped, the poor, the unemployed), educational specialists, and students. At the same time, in addition to their administrative, teaching and research duties, university teachers of primary health care will need to devote a certain amount of their time (at least 50%) to professional practice.

In the training of university teachers for primary health care much attention should be given to ways of:

- determining the primary health care skills and competencies, and the level of achievement, that students should be expected to show they have acquired at different stages of the undergraduate course;

- assuring the conditions in which these skills and competencies may be acquired and tested, including the right of students to take responsibility for their own learning;

- organizing and coordinating the time and other educational resources and facilities that can be shared with other departments, faculties and disciplines;

- reflecting in undergraduate education findings from the monitoring and evaluation of the performance of graduates in primary health care and from experience with continuing education for primary health care;

- developing valid and objective test items for the evaluation of students in decentralized, community based educational settings;

- assessing the performance of students in the various aspects or components of primary health care (6);

- assessing the suitability and quality of training facilities;

- helping the field training staff (primary health care practitioners) to develop their supervisory and training skills;

- supervising and monitoring the performance of field staff as trainers and supervisors;

- counselling students with regard to personal problems that arise in their training in family and community health.

The seminar stressed the need to create postgraduate departments of general practice which, among their functions, would train the general practitioners needed to staff the primary health care settings in which undergraduate education will take place.

RESEARCH RELATED TO EDUCATION FOR PRIMARY HEALTH CARE

There is a need for purposes of primary health care education to extend research methodology beyond the conventional biomedical research that predominates in medical schools and in national medical research organizations to the bio-behavioural research carried out in other university faculties. The conventional research paradigms of scientific medicine are only partly applicable to the new areas of primary health care upon which much of the prevention of disease and disability - and the promotion of health - will depend, namely community participation, multisectoral cooperation, and efforts to improve the quality of life of the underprivileged, the disabled, and other at-risk groups.

First, however, even within existing paradigms of biomedical research there is much scope for studying the primary health care dimensions and applications of fields as diverse as, e.g. epidemiology, clinical pharmacology and endocrinology. The community and the primary health care setting is often a more suitable basis than the hospital ward or the laboratory for research into the prevention and management of the principal health problems of industrialized societies. Medical and other health care students can be valuable agents in bringing researchers into contact with communities. In the community, also, other university researchers, especially behavioural scientists, can find common ground with health researchers. Crucial issues in primary health care, such as subjective and individual views or notions of health, the potential of self-care and of lay care, and the exercise (and methods) of community responsibility for its

own health, need the research methods of the behavioural sciences (e.g. psychology, economics, anthropology, sociology, political science). These open up prospects of a much broader and more sophisticated attack on health problems than can be made by biomedical research alone. They are not commonly represented in medical schools. Even within the biomedical sciences most medical schools have not built bridges with non-medical sciences in areas with obvious scope and need for such bridging, such as the neurosciences and transmitter systems.

Community based research is needed to identify the needs of communities, to clarify the roles and responsibilities of primary health care workers, and to discover the advantages and disadvantages of different patterns of practice.

Research in primary health care must be concerned with problems which are different from those at which the predominant biomedical research is directed. First, there is a wider range of problems to be solved. Many of the problems which people bring to health professionals arise from their lifestyle, including their nutritional practices and social behaviour. Second, the quality of practice in primary health care depends critically, more than in some other branches of medicine, upon human interaction - the client/professional relationship. Primary health care workers have to be readily accessible; they must be sensitive and skilled educators and communicators who are welcome in homes and workplaces and by all members of families. The time-scale of primary health care is different from that of secondary or tertiary care: it may take several years to develop such deep relationships. The outcome of primary health care cannot be evaluated solely against technical criteria: the satisfaction of the patient or client and the degree of participation of the patient in the process are fundamental. Finally, the primary health care worker is a generalist, not a specialist, and consequently his range of responsibilities includes, besides treatment, the prevention of disease and disabilities, health promotion, concern for all systems of the body, and concern for emotional health as well as for physical health.

For these reasons, the techniques of behavioural science research are often more appropriate to primary health care than those of clinical and biological research. Similarly, the statistical methods used must often be non-parametric or distribution free, unlike those, such as the *t* test, so often used in biomedical research, which assume normally distributed populations. Research on how resources are provided and received, so-called operational research, is a necessary and valid part of research in primary health care.

RECOMMENDATIONS

The recommendations made by the participants were directed at governments, universities and medical schools, and the WHO Regional Office for Europe.

1. In each country, a national "core group" should be established to act as a catalyst in promoting primary health care in the education of health personnel. It would act also as a national and international clearing-house for information on activities concerned with education for primary health care.

2. In each country, acceptable standards for the practice of primary medical care as a major element of primary health care should be elaborated and the competencies needed for graduating students in primary health care should be defined; it would also serve the purpose of educational planning and evaluation.

3. With regard to educational planning and curriculum development, it was recommended to the governmental bodies (agencies) in countries where they have a statutory function in decision-making about curricula, that proper emphasis to primary health care education should be given in educational goals and objectives.

4. The bodies responsible for curriculum planning should be advised on the limitations of subject centred curricula, and the rationale of competency based, problem solving learning. It could be of great importance in establishing medical and health personnel curricula relevant to primary health care teaching.

5. The cooperation of specialist clinical teachers with generalists (practitioners) should be sought to ensure the proper balance between competencies needed for general practice and hospital based specialist medicine in the undergraduate curriculum.

6. Research in support of primary health care delivery and of the education of all health professionals for primary health care should be encouraged and become a concern of the European Advisory Committee for Medical Research (EACMR).

7. The seminar endorsed the recommendation of the WHO Consultation on Mobilizing Universities for Health for All (7) for the establishment of a task force to be responsible for involving universities in "health for all" action, and particularly for the transmission and distribution of information on developments in this field which should be of specific significance for medical education in the European Region.

8. The WHO Regional Office for Europe should cooperate closely with international professional associations in Europe concerned with medical education, for example the Association for Medical Education in Europe (AMEE) and the Association of Medical Deans in Europe (AMDE), to publicize the reorientation of medical education towards primary health care.

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Annex 1

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Annex 2

SET OF FIVE QUESTIONS SENT TO PARTICIPANTS

1. What will be the new or modified functions or tasks of primary medical care practitioners which the regional strategy will demand?

2. What should be the corresponding changes that these new or modified functions or tasks will call for in undergraduate medical education?

3. Can you suggest the potential contributions of different medical school departments or disciplines, or combinations of disciplines, to the preparation of medical students for the competencies and skills envisaged?

4. The steps needed to organize practical training in primary health care in the community, with regard to quality control of services and education, educational management, health service management, funding, etc?

5. If the modifications you suggest imply collaboration between departments and/or collaboration between the medical school and health administration or other institutions or individuals in the community, what will be the organizational and managerial requirements, and what changes will these demand?

Annex 3

PARTICIPANTS

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SUMMARIES IN FRENCH, GERMAN AND RUSSIAN

RESUME

Introduction

Le séminaire a réuni 22 participants : 19 conseillers temporaires et trois fonctionnaires de l'OMS.

Les soins de santé primaires (SSP) constituent la base de la stratégie régionale en vue de l'instauration de la santé pour tous d'ici l'an 2000, adoptée par les Etats Membres de la Région européenne. Cette stratégie implique de profondes modifications de la pratique comme de l'organisation et du financement des soins de santé, et une réorientation fondamentale de l'enseignement médical et infirmier.[a]

Bien que les Etats Membres n'aient pas encore établi leur stratégie nationale pour la santé pour tous ou indiqué quelles formes prendront les soins de santé primaires, on peut déduire à partir de la stratégie régionale, quels seront les nouveaux rôles et fonctions des professionnels des soins de santé primaires, ou comment ces rôles et fonctions évolueront, les objectifs qui en découleront pour les systèmes d'enseignement, les conséquences de l'adoption de ces objectifs sur les politiques en matière d'enseignement comme sur le contenu des cours et l'organisation et la gestion des centres d'enseignement, et enfin les rapports entre le système d'enseignement et le système de soins.

Les structures et les formes des soins de santé primaires et des études médicales les plus courantes en Europe constituent l'un des principaux obstacles à surmonter pour généraliser l'adoption des SSP en tant qu'élément essentiel pour la mise en oeuvre de la stratégie régionale. C'est pourquoi le Bureau régional de l'OMS pour l'Europe a organisé une réunion de représentants d'administrations sanitaires, de l'enseignement médical, des soins de santé primaires et des étudiants en médecine afin d'identifier les mesures

[a] Stratégie régionale en vue de l'instauration de la santé pour tous d'ici l'an 2000. Copenhague, Bureau régional de l'OMS pour l'Europe, 1982 (EUR/RC30/8 Rev.2).

que prennent ou que devront prendre les responsables de l'enseignement et des administrations sanitaires pour surmonter les obstacles et adapter les études aux soins de santé primaires. Il s'agit notamment de déterminer les aspects structurels, administratifs et financiers des systèmes de soins et d'enseignement médical, ainsi que la nature des divers liens qui les unissent.

Le rapport de la réunion devra permettre aux responsables nationaux de la santé et de l'enseignement de déterminer les modifications et l'appui à apporter au système d'enseignement médical afin de former les praticiens des soins de santé primaires dans les meilleures conditions possibles.

Le rôle de l'enseignement médical

Le séminaire était davantage consacré aux nouveaux rôles et fonctions pour lesquels il faudra former les praticiens des soins de santé primaires, ou à l'évolution de ces rôles et fonctions, afin de pouvoir appliquer la stratégie régionale qu'à la préparation aux soins médicaux primaires (c'est-à-dire la médecine générale). Cependant, il est apparu clairement que les soins médicaux primaires sont loin d'être généralisés, que ce soit en tant que discipline ou qu'enseignement. Il reste encore un grand nombre de personnes vulnérables qui ne reçoivent pas les soins qu'elles pourraient recevoir. Etant donné que les soins médicaux primaires dans la Région européenne sont généralement considérés comme les fondations qui permettront la mise en oeuvre des SSP, les efforts doivent essentiellement porter sur leur amélioration, leur généralisation et la modification de leur structure afin de mettre les progrès de la médecine et de la science à la portée de tous. L'une des tâches de l'enseignement médical consiste à encourager ce type de soins médicaux primaires plutôt qu'à perpétuer les pratiques actuelles. Le médecin généraliste exerçant dans le domaine des soins de santé primaires devra être formé, informé, apte à la communication et être capable de travailler au sein d'une équipe pluridisciplinaire.

Il existe, dans un petit nombre de pays, certains éléments permettant de passer de la médecine générale aux soins de santé primaires, tant du point de vue des prestations que de l'enseignement. Dans de nombreux

autres pays de la Région cependant, des changements radicaux s'imposent dans ces deux domaines en raison de la structure actuelle des SSP et de la totale inexistence de formation à cette discipline.

Les obstacles à la formation aux soins de santé primaires dans l'enseignement médical

Les obstacles à la réorientation nécessaire de l'enseignement médical sont de nature soit à empêcher une évolution générale de l'enseignement, soit sont spécifiques de la pratique des soins de santé primaires et de la formation dans ce domaine. Dans le premier cas, il faut principalement transformer la structure actuelle de l'enseignement médical, qui est d'essence universitaire et cloisonné en disciplines et en spécialités, en un enseignement fondé sur la compétence, faisant la place à la recherche de solutions et destiné en priorité aux généralistes. Le deuxième cas est notamment caractérisé par la passivité des habitudes médicales actuelles, c'est-à-dire que le médecin attend qu'un patient présentant des symptômes bien définis vienne le voir et où il n'existe aucune incitation à pratiquer une médecine d'anticipation, préventive, ou à utiliser des moyens non médicaux pour la prévention de la maladie ou la promotion de la santé.

L'influence prédominante d'une médecine spécialisée et de haute technicité se manifeste dans les programmes des études médicales, que de nombreux pays considèrent comme une première étape vers la spécialisation, et qui n'ont que peu de rapport avec les principes de la médecine générale.

Au niveau gouvernemental, l'absence de tradition de coopération entre différents secteurs, qui se manifeste, par exemple, par l'indépendance du secteur de la santé et du secteur de l'enseignement supérieur, ou par la contradiction entre les intérêts économiques ou budgétaires du gouvernement et les mesures de protection de la santé publique, constitue un obstacle supplémentaire.

Les obstacles à surmonter pour essayer de réorienter l'enseignement médical vers les soins de santé primaires sont notamment l'attitude actuelle, le manque de motivation, les intérêts des différentes parties

concernées, l'insuffisance des connaissances, une communication peu développée, l'absence de tradition et les structures actuelles de la médecine et de l'enseignement. Ces obstacles existent au niveau du gouvernement, de l'université, des écoles de médecine, des professionnels de la santé et de la collectivité.

La réorientation de l'enseignement médical vers les soins de santé primaires

Les conditions nécessaires à la réorientation de l'enseignement médical vers les soins de santé primaires sont notamment :

- que chaque pays adopte une stratégie de la santé pour tous qui précise la forme future des soins de santé primaires et y affecte les ressources nécessaires pour que ceux-ci deviennent "la fonction centrale et la principale priorité" du système de santé;

- définir précisément et faire accepter la place de l'enseignement médical, qui devra collaborer à la mise en oeuvre de la stratégie nationale avec le gouvernement et les autres parties concernées par les soins de santé primaires afin de développer ces derniers grâce à la recherche et à un enseignement fondé sur la notion de prestations de services;

- informer le public comme les hommes politiques et les administrateurs dont les décisions ont des conséquences pour les SSP de la nature et de la portée des soins de santé primaires;

- définir, ce qui est essentiel pour la préparation des programmes et pour assurer un enseignement de valeur, les connaissances pratiques et théoriques ainsi que les compétences en soins de santé primaires, que devront avoir les étudiants à la fin de leurs études (cette tâche sera assurée par un organisme compétent où seront également représentés les intérêts des soins de santé primaires);

- utiliser des méthodes pédagogiques confirmées, depuis la préparation des cours jusqu'à l'évaluation des étudiants et des programmes, et assurer une

représentation satisfaisante des divers intérêts pluridisciplinaires et multisectoriels lors de la préparation des programmes et pendant la formation;

- établir formellement des accords entre les écoles de médecine et les services communautaires de santé et connexes, afin de permettre à ces écoles d'utiliser une collectivité suffisamment importante et représentative pour la formation et la recherche. De plus, les écoles auraient ainsi la possibilité de coopter des praticiens des soins de santé primaires pour former et superviser des étudiants ou des groupes d'étudiants;

- développer progressivement les services communautaires de formation aux soins de santé primaires afin de répondre aux critères énoncés dans la stratégie régionale (point 20) par exemple en ce qui concerne la participation de la communauté, le travail en équipes pluridisciplinaires et l'aide apportée aux individus afin que ceux-ci soient plus largement responsables de leur propre santé;

- définir en détail les fonctions et les compétences pédagogiques des enseignants en soins de santé primaires et formuler en conséquence les programmes de formation d'enseignants.

Les soins de santé primaires dans le cadre des écoles de médecine

Si certains arguments plaident en faveur de la création de chaires et de départements de soins de santé primaires, une telle mesure présente le risque de restreindre à une partie de l'université un aspect des soins de santé auquel peuvent contribuer de nombreuses disciplines et qui est davantage le regroupement d'un ensemble de savoir-faire qu'un ensemble théorique. Les participants ont proposé de regrouper les départements ou les services des écoles de médecine, d'autres disciplines médicales et éventuellement d'autres disciplines universitaires qui ont beaucoup à apporter aux soins de santé primaires afin de créer un ensemble puissant, directement responsable de la formation, de la recherche et de la prestation de services communautaires dans ce domaine. En ce qui concerne les écoles de médecine, les services concernés seraient la

médecine générale, la médecine sociale, la médecine du travail, l'épidémiologie, la gériatrie, les soins de longue durée et la psychiatrie sociale. Une telle organisation aurait l'avantage de ne pas séparer l'enseignement spécialisé de l'enseignement axé sur les services communautaires. Il faudrait en outre que les divers services cliniques apportent leur contribution afin de permettre aux étudiants de maîtriser la médecine clinique telle qu'elle est pratiquée par les généralistes, de leur apprendre à faire la distinction entre la partie générale et la partie spécialisée de leur domaine pour leur permettre d'atteindre le haut degré de compétence clinique en médecine générale essentiel aux soins de santé primaires au lieu d'avoir à maîtriser des bribes des techniques trop sophistiquées utilisées en spécialisation. A cette fin, des enseignants de haut niveau devraient exercer dans les centres de soins de santé primaires.

Les écoles de médecine pourraient comporter, à côté des groupes se consacrant à la médecine préventive au niveau de la communauté et aux diverses spécialités cliniques, un troisième "groupe actif" chargé de la promotion et de la direction des études, comme c'est déjà le cas dans les écoles modernes. Ce groupe pourrait encourager un enseignement fondé sur l'acquisition de savoir-faire et la capacité à résoudre des problèmes et réduire le cloisonnement de l'enseignement qui est largement incompatible avec la formation aux soins de santé primaires. Il pourrait également aider les enseignants responsables des soins de santé primaires à mettre en oeuvre le programme dans une large mesure décentralisé et fondé sur la communauté, nécessaire à l'enseignement de cette discipline, et notamment aider les nombreux praticiens qui devraient être cooptés par les écoles de médecine à former et à superviser les étudiants.

L'université et les soins de santé primaires

Etant donné que l'instauration de la santé pour tous ne dépend pas uniquement du secteur sanitaire, il faudrait rechercher et utiliser les moyens offerts par l'ensemble du système universitaire (ou du système d'enseignement supérieur). Le groupe chargé des soins de santé primaires au sein des écoles de médecine pourrait trouver des alliés puissants dans les conseils d'administration

des universités et dans diverses facultés ou départements universitaires (sciences économiques, sociologie, sciences politiques, géographie, génie biologique, architecture, urbanisme, agriculture, etc.). L'université pourrait également financer des recherches communes pluridisciplinaires.

Recommandations

1. Il faudrait créer dans chaque pays un organisme national qui serait chargé de concrétiser toutes les actions visant à encourager la formation du personnel de santé aux soins de santé primaires et de recueillir et de diffuser les informations sur les activités entreprises au niveau national et international en ce qui concerne cette formation.

2. Les groupes nationaux agissant en faveur de l'enseignement des soins de santé primaires devraient bénéficier de bourses OMS.

3. Le Bureau régional de l'OMS pour l'Europe devrait coopérer étroitement avec les associations professionnelles internationales européennes intéressées par l'enseignement médical afin de réorienter cet enseignement vers les soins de santé primaires.

ZUSAMMENFASSUNG

Einleitung

An diesem Seminar nahmen 19 Berater auf Zeit und 3 WGO-Mitarbeiter teil.

Die primäre Gesundheitsversorgung spielt in der von allen Mitgliedstaaten der europäischen WGO-Region offiziell gebilligten Regionalstrategie zur Erreichung des Ziels "Gesundheit für alle bis zum Jahr 2000" eine zentrale Rolle. Die Verwirklichung des Ziels setzt umfangreiche Änderungen voraus in bezug auf Berufspraxis, Struktur und Finanzierung der Gesundheitsversorgung und die medizinische sowie krankenpflegerische Ausbildung.[a]

Obwohl die Mitgliedstaaten ihre eigenen Strategien für "Gesundheit 2000" noch nicht ausgearbeitet und die zukünftige Form der primären Gesundheitsversorgung noch nicht festgelegt haben, lassen sich aus der Regionalstrategie bereits folgende Bereiche ableiten: die neuen bzw. geänderten Hauptfunktionen der Fachkräfte in der primären Gesundheitsversorgung, die entsprechenden Ausbildungsziele, die Implikationen dieser Ziele für die Ausbildungspolitik, Organisation und Leitung der Ausbildungsstätten, die Handhabung des Lehrstoffs und die Beziehung zwischen Ausbildungs- und Gesundheitsversorgungssystemen.

Die in der Europäischen Region hauptsächlich anzutreffenden Strukturen und Formen der primären medizinischen Betreuung und medizinischen Ausbildung stellen beim Ausbau der primären Gesundheitsversorgung, die ein Kernstück der Regionalstrategie darstellt, ein grosses Hindernis, aber auch eine Herausforderung dar. Deshalb hat das WGO-Regionalbüro für Europa für Vertreter aus den Bereichen Gesundheitsverwaltung, medizinische Ausbildung, Primärversorgung und für Medizinstudenten eine Tagung veranstaltet mit folgender Zielsetzung: Festlegung

[a] Regionale Strategie zur Erreichung des Ziels "Gesundheit für alle bis zum Jahr 2000". Kopenhagen, WGO-Regionalbüro für Europa, 1982 (EUR/RC30/8 Rev. 2).

überwinden. Diese Schritte und Engpässe umfassen

der vom Ausbildungs- und Gesundheitsverwaltungswesen durchzuführenden Schritte, um die medizinische Ausbildung den Belangen der primären Gesundheitsversorgung anzupassen und die dabei auftauchenden Schwierigkeiten zu strukturelle, organisatorische und finanzielle Aspekte der Gesundheitsversorgung und medizinischen Ausbildung sowie verschiedene Aspekte ihrer gegenseitigen Beziehungen.

Der Tagungsbericht soll den Behörden des Gesundheits- und Erziehungswesens als Anhaltspunkt dafür dienen, wie die medizinische Ausbildung modifiziert und unterstützt werden kann, um den angehenden medizinischen Fachkräften der primären Gesundheitsversorgung eine optimale Ausbildung zu ermöglichen.

Ziel der medizinischen Ausbildung

Im Mittelpunkt des Seminars standen nicht Ausbildungsfragen in Verbindung mit der medizinischen Primärversorgung (oder Allgemeinpraxis), sondern die neuen bzw. modifizierten Rollen und Funktionen, für die das Personal der primären Gesundheitsversorgung ausgebildet werden muss, wenn man die Regionalstrategie praktisch umsetzen will. Es erwies sich aber, dass die medizinische Primärversorgung weder als Disziplin noch als Unterrichtsgebiet eine Selbstverständlichkeit ist. Ein Grossteil der anfälligen Bevölkerungsgruppen erhält nicht die verfügbaren Betreuungsleistungen. Da in Europa die medizinische Primärversorgung normalerweise als Ausgangspunkt für die neuen Elemente der primären Gesundheitsversorgung angesehen wird, muss man sich auf die Anhebung ihrer Standards, eine Ausweitung und eine Änderung ihrer Struktur konzentrieren, damit die Vorteile der medizinischen Wissenschaft und modernen Technologie allen zugänglich gemacht werden können. Eine der Aufgaben der medizinischen Ausbildung muss darin bestehen, diese Art der primären medizinischen Betreuung zu fördern und nicht nur die gegenwärtigen Praxisnormen wiederzugeben. Der Allgemeinarzt in der primären Gesundheitsversorgung muss über eine erzieherische, informatorische, kommunikative Befähigung und Erfahrung in der multidisziplinären Teamarbeit verfügen.

In relativ wenig Ländern gibt es hinsichtlich der Leistungserbringung und Ausbildung eine Grundlage für den Ausbau der medizinischen Primärversorgung zur

umfassenderen primären Gesundheitsversorgung. In manchen anderen Ländern der Region werden angesichts der Struktur der medizinischen Primärversorgung und ihrer totalen ausbildungsmässigen Vernachlässigung radikale Änderungen durchgeführt werden müssen.

Hindernisse bei der Eingliederung der primären Gesundheitsversorgung in die medizinische Ausbildung

Bei der notwendigen Neuausrichtung der medizinischen Ausbildung treten Hindernisse auf, einmal in Verbindung mit der medizinischen Ausbildung als solcher und einmal besonders in Verbindung mit der primären Gesundheitsversorgung sowohl in der Praxis als auch in der Ausbildung. Im ersten Fall handelt es sich hauptsächlich um den Abbau der vorherrschenden akademischen, gefächerten und spezialisierten Struktur des medizinischen Ausbildungsbetriebs; an seine Stelle soll ein praktisch anwendbares Fachkönnen, die Fähigkeit zur Problemlösung und eine allgemeinmedizinische Ausrichtung treten. Im zweiten Fall dreht es sich um das bisherige passive Verhalten in der medizinischen Praxis - die Ärzte erwarten, dass die Patienten mit deutlich ausgeprägten Symptomen zu ihnen kommen; es wird nicht zu einer vorgreifenden präventiven Medizin oder einer nichtmedizinischen Prophylaxe bzw. einer Gesundheitsförderung angeregt.

Der vorherrschende Einfluss der hochtechnischen Gerätemedizin spiegelt sich im medizinischen Lehrstoff wider, was in manchen Ländern als erster Schritt zur Spezialisierung betrachtet wird und im Gegensatz zu den Prinzipien der Allgemeinmedizin steht.

Ein Hindernis besteht auch behördenseitig: traditionsgemäss besteht keine enge Zusammenarbeit zwischen den verschiedenen Sektoren. Beispielsweise ist der Gesundheitsbereich von der akademischen Ausbildung getrennt; desgleichen besteht ein Interessenkonflikt zwischen der Fiskalpolitik des Staates und seiner Aufgabe, die Volksgesundheit zu schützen. Die bei der Neuausrichtung der medizinischen Ausbildung im Sinne der primären Gesundheitsversorgung zu erwartenden Hindernisse umfassen u.a.: Haltung, Motivation, berechtigte Interessen, Wissensdefizit, Kommunikation, Tradition sowie Strukturen der Praxis und Ausbildung. Diesen Hindernissen

begegnet man in verschiedenen Bereichen: Staat/Regierung, Universität, medizinische Fakultät, (akademische) Berufe und Gemeinwesen.

Neuausrichtung der medizinischen Ausbildung im Sinne der primären Gesundheitsversorgung

Voraussetzungen für eine Änderung der medizinischen Ausbildung im Hinblick auf die primäre Gesundheitsversorgung sind:

- Jedes Land sollte eine eigene Strategie zur Erreichung des Ziels "Gesundheit 2000" ausarbeiten; dabei ist anzugeben, welche Form die primäre Gesundheitsversorgung haben soll; es sind diesem Sektor die Mittel zuzuteilen, die erforderlich sind, damit er die "zentrale Funktion und Mittelpunkt" des Gesundheitswesens werden kann.

- Entwicklung einer genau definierten und vereinbarten medizinischen Ausbildung im Sinne der Strategie und mit einer partnerschaftlichen Verbindung zum Staat sowie zu anderen Bereichen der primären Gesundheitsversorgung, um durch Forschung und praktische Ausbildung zum Konzept der Grundversorgung beizutragen.

- Unterweisung der Öffentlichkeit sowie der Politiker und leitenden Verwaltungsfachleute, die einen Einfluss auf das Konzept der Grundversorgung ausüben können, hinsichtlich Art und Umfang der primären Gesundheitsversorgung.

- Als wichtige Grundvoraussetzung für die Curriculumplanung und effektive Wissensaufnahme sollte eine Behörde, in der die Belange der primären Gesundheitsversorgung vertreten werden, das dem Kandidaten abverlangte praktische und wissenschaftliche Können auf den entsprechenden Leistungsstufen innerhalb der Grundversorgung festlegen.

- Es müssen zweckmässige pädagogische Verfahren angewandt werden, von der Curriculumplanung bis zur Evaluierung der Studenten und Programme; ausserdem

müssen bei der Planung der Ausbildung und deren Durchführung die multidisziplinären und multisektoralen Interessen gebührlich vertreten sein.

- Zwischen der medizinischen Lehranstalt und dem Gesundheitsbetreuungswesen sowie gesundheitsbezogenen Dienstleistungsbereichen sollte eine formelle Vereinbarung bestehen, damit die Lehranstalt in einem ausreichend grossen und repräsentativen Gemeinwesen Ausbildungs- und Forschungsprojekte durchführen kann; dann könnte die Lehranstalt auch Fachkräfte der Primärversorgung zur Ausbildung und Beaufsichtigung einzelner Studenten sowie kleiner Gruppen hinzuziehen.

- Die primäre Gesundheitsversorgung des Gemeinwesens am Ausbildungsort sollte sich allmählich soweit entwickeln, dass die in der Regionalstrategie (Punkt 20) angegebenen Kriterien, z.B. Mitspracherecht der Bevölkerung, multidisziplinäre Teamarbeit und Erziehung der Bevölkerung im Sinne einer grösseren Verantwortlichkeit für ihre persönliche Gesundheit, erfüllt werden.

- Die den Lehrkräften für die Grundversorgung abverlangten Funktionen und Managementfähigkeiten müssen genau festgelegt sein, die Lehrerausbildung ist entsprechend auszuformen.

Die primäre Gesundheitsversorgung in der medizinischen Fakultät

Auch wenn einiges dafür spricht, Lehrstühle und Fachbereiche für die primäre Gesundheitsversorgung einzurichten, läuft man dabei doch Gefahr, einen Zweig der Gesundheitsversorgung, zu dem viele andere Bereiche beizutragen haben und der nicht so sehr ein geschlossenes Wissensgebiet, sondern eine Kombination von Teildisziplinen darstellt, in fachbereichliche Grenzen zu zwängen. Es wurde eine Organisationsform vorgeschlagen, bei der Abteilungen und Fachbereiche der medizinischen Lehranstalt, sonstige Gesundheitsversorgungsdisziplinen und eventuell weitere Universitätsfachbereiche, die zur Grundversorgung beitragen können, gemeinsam einen starken Sektor der medizinischen Fakultät bilden, der für Ausbildung, Forschung und kommunale Leistungserbringung im

Rahmen der Grundversorgung verantwortlich ist. Die diesbezüglichen Fachbereiche wären: Allgemeinpraxis, Sozialmedizin, Arbeitsmedizin, Epidemiologie, Geriatrie, Langzeitbetreuung und Sozialpsychiatrie. Bei einer solchen Struktur sollte vermieden werden, dass in der medizinischen Ausbildung zwei äussere Pole entstehen, die spezialisierte klinische Ausbildung einerseits und die auf das Gemeinwesen abgestimmte Ausbildung andererseits. Die klinischen Abteilungen sollten dabei ihren eigenen Beitrag leisten, damit die Studenten jene Gebiete der klinischen Medizin sich aneignen, die der Allgemeinarzt bearbeitet. Diese Abteilungen sollten in der Ausbildung dafür sorgen, dass bei der Behandlung ihrer Fachthemen zwischen den allgemeinmedizinischen und spezialisierten Aspekten unterschieden wird, damit die Studenten die für die Grundversorgung wesentliche allgemeinmedizinische Kompetenz erwerben können, statt Fragmente einer überproportional anspruchsvollen Technologie der Fachmedizin erlernen zu müssen. Bei einem solchen Vorgehen sollten die massgebenden klinischen Lehrkräfte gleichzeitig in Einrichtungen der primären Gesundheitsversorgung tätig sein.

Neben den präventiv, kommunal orientierten und den spezialisierten klinischen Bereichen an der medizinischen Lehranstalt ist ein dritter Bereich denkbar, nämlich die Gestaltung und praktische Durchführung der Ausbildung; diesen Bereich gibt es bereits an modernen medizinischen Fakultäten. Der letztgenannte Bereich könnte in der Ausbildung Problemlösungstechniken und die Aneignung praktisch verwertbaren Fachkönnens vermitteln und die Ausbildungsfächerung abbauen, die sich mit einer Ausbildung für die primäre Gesundheitsversorgung schlecht verträgt. Dadurch würde es den für die Grundversorgung zuständigen Lehrkräften auch leichter gemacht, die für die Grundversorgung typischen, meist dezentralisierten, kommunal ausgerichteten Ausbildungsprogramme organisatorisch durchzuführen. Dieser Ausbildungsbereich könnte ausbildungs- und aufsichtsmässig der grossen Gruppe der aus der Gesundheitsversorgung kommenden Fachkräfte behilflich sein, die zur praktischen Ausbildung der Studenten hinzugezogen wird.

Primäre Gesundheitsversorgung und Universität

Da der Gesundheitssektor allein nicht das gesamte Gesundheitsspektrum behandeln kann, ist das Potential der Universität, bzw. der höheren Ausbildung, in ihrer Gesamtheit zu untersuchen und auszunutzen. Der Bereich Grundversorgung an der medizinischen Fakultät sollte in den Universitätsgremien und den zahlreichen anderen Fakultäten und Fachbereichen einflussreiche Verbündete haben, so z.B. in den Bereichen Volkswirtschaft, Soziologie, politische Wissenschaften, Geographie, Biotechnik, Architektur, Stadtplanung und Landwirtschaft. Für eine Forschung auf dem Gebiet der Zusammenarbeit zwischen den Fakultäten könnten Universitätsmittel zur Verfügung gestellt werden.

Empfehlungen

1. In jedem Land sollte man ein überregionales Gremium einrichten, das als Katalysator wirken soll in bezug auf die Förderung der primären Gesundheitsversorgung im Zusammenhang mit der Ausbildung von Gesundheitspersonal; das Gremium könnte auch auf überregionaler und internationaler Ebene als Informationsaustauschstelle in Verbindung mit der Ausbildung für die Grundversorgung dienen.

2. Man sollte im einzelstaatlichen Bereich WGO-Stipendiengelder einsetzen, um die Ausbildung des Gesundheitspersonals im Hinblick auf die primäre Gesundheitsversorgung zu fördern.

3. Um die medizinische Ausbildung zugunsten der primären Gesundheitsversorgung zu beeinflussen, sollte das WGO-Regionalbüro für Europa eng mit internationalen, europäischen Fachverbänden für die medizinische Ausbildung zusammenarbeiten.

РЕЗЮМЕ

Введение

На семинаре присутствовали 22 участника: 19 временных советников и 3 штатных сотрудника ВОЗ.

Первичной медико-санитарной помощи (ПМСП) принадлежит ключевая роль в региональной стратегии достижения здоровья для всех к 2000 году, официально одобренной государствами - членами Европейского региона ВОЗ. Реализация этой стратегии предполагает осуществление крупных преобразований в профессиональной практике, в области организации и финансирования медико-санитарной помощи, а также фундаментальную переориентацию подготовки кадров в области медицины и сестринского дела.[а]

Хотя в государствах-членах пока еще не составлены национальные стратегии достижения здоровья для всех и не разработаны формы участия работников ПМСП в их реализации, представляется возможным, исходя из региональной стратегии, определить наиболее важные новые или видоизмененные старые роли и функции работников первичной медико-санитарной помощи в ходе реализации ЗДВ2000, определить цели систем обучения, задачи по выполнению этих целей в рамках проводимой политики в области обучения, рассмотреть вопросы организации и руководства деятельностью учебных заведений и разработкой учебных программ, а также определить взаимоотношения между системами обучения и медико-санитарной помощи.

[а] Региональная стратегия достижения здоровья для всех к 2000 году. Копенгаген, Европейское региональное бюро ВОЗ, 1982

Доминирующие структуры и формы первичной медико-санитарной помощи и медицинского образования в странах Европейского региона являются одним из основных препятствий, которые стоят на пути широкого распространения подхода к первичной медико-санитарной помощи как к одному из ключевых условий реализации региональной стратегии. В связи с этим Европейское региональное бюро ВОЗ провело совещание с участием представителей руководящих органов здравоохранения, медицинского образования, первичной медико-санитарной помощи, а также студентов медицинских вузов для определения тех поэтапных мер со стороны руководства органов здравоохранения и обучения, которые потребуется провести (или которые проводятся в настоящее время) с целью перестройки систем медицинского обучения с учетом потребностей первичной медико-санитарной помощи и тех проблем, которые в этой области предстоит решить. Эти меры и проблемы касаются структурных, организационных и финансовых аспектов систем медико-санитарной помощи и медицинского образования, а также различных аспектов их взаимосвязей.

Отчет о совещании составлен с учетом его последующего использования руководством здравоохранения и медицинского образования в странах в целях определения путей совершенствования систем медицинского образования и их поддержки для создания оптимальных условий подготовки врачей общего профиля в области первичной медико-санитарной помощи.

Задача медицинского обучения

В центре внимания участников Семинара были не вопросы подготовки к оказанию первичной медико-санитарной помощи (или ведению общей практики), а новые или видоизмененные старые роли и функции работников первичной медико-санитарной помощи, обучение которым необходимо для реализации региональной стратегии. Очевидно, однако, что нельзя рассматривать в качестве само собой разумеющегося первичную медико-санитарную помощь как вид деятельности или учебную дисциплину. Значительное число нуждающихся в помощи людей не получают помощи, на которую они могли бы рассчитывать. Поскольку первичное медико-санитарное обслуживание в Европейском регионе рассматривается в целом как основа для развития новых элементов ПМСП, основные

усилия должны быть направлены на повышение уровня этой помощи, расширение масштабов работы по ПМСП и изменение ее структуры в целях наилучшего использования достижений медицинской науки и современной технологии в интересах населения. Одна из задач медицинского обучения должна заключаться скорее в содействии развитию первичного медико-санитарного обслуживания в этом направлении, чем в отображении существующих норм практической деятельности. Работник ПМСП общего профиля должен владеть необходимыми навыками педагогической, информационной, коммуникационной и многодисциплинарной бригадной работы.

Сравнительно немногие страны располагают достаточной основой для преобразования практики первичного медицинского обслуживания в деятельность по оказанию медико-санитарной помощи как в рамках действующих служб, так и в сфере обучения. Во многих странах Региона ввиду существующей структуры первичного медицинского обслуживания и в связи с полным отсутствием учебных программ по ПМСП для студентов медицинских вузов для достижения поставленной цели будут необходимы коренные преобразования как в той, так и в другой областях.

Проблемы преподавания ПМСП для студентов медицинских вузов

Препятствия, стоящие на пути проведения необходимой переориентации медицинского образования, включают некоторые из проблем, которые тормозят преобразования в области медицинского обучения в целом, а также развитие как общей практики, так и подготовки кадров в области ПСМП. Для решения первой задачи необходимо в основном отойти от преимущественно академического, кафедрального, специализированного подхода к учебным программам и перейти к их разработке, учитывающей необходимый уровень компетенции, задачи по решению стоящих проблем и преимущественной подготовке специалистов общего профиля. Решение второй задачи связано с наличием широко распространенной практики медицинского обслуживания, при которой врачи ждут обращения к ним пациентов с очевидными симптомами заболевания и которая не предполагает проведения никаких предупреждающих или профилактических мероприятий, равно как и применения немедицинских средств в целях профилактики и укрепления здоровья.

Доминирующая роль специализированной медицинской помощи с использованием новейшей технологии нашла свое отражение в учебных программах медицинских вузов, которые во многих странах рассматриваются как начальный этап специализации и слабо ориентированы на обучение принципам общей практики.

Одним из препятствий, тормозящих работу на правительственном уровне, является отсутствие традиций сотрудничества различных секторов. Одним из примеров этого является независимый характер деятельности в секторах здравоохранения и высшего образования; другим - несоответствие экономических или финансовых интересов правительства задачам политики в области охраны здоровья населения.

К числу проблем, которые необходимо иметь в виду при решении задач в области переориентации медицинского образования в направлении ПМСП, следует отнести проблемы, связанные с отношением и мотивацией, узкоспециальными интересами, недостатком знаний, контактами, традициями, структурой и методами практической деятельности и обучения. Эти проблемы стоят на различных уровнях - на уровне правительства, вуза, медицинской школы, профессиональной деятельности и работы общин.

Переориентация медицинского обучения в направлении ПМСП

Условия, необходимые для переориентации медицинского обучения в направлении ПМСП, включают:

- утверждение в каждой стране национальной стратегии достижения здоровья для всех с указанием форм развития ПМСП и ресурсов, выделяемых для превращения ПМСП в "основной и главный вид деятельности" в рамках системы здравоохранения;

- постановка четких и согласованных задач в области медицинского обучения в поддержку разработанной стратегии, деятельности правительственных органов и служб ПМСП по развитию первичного медико-санитарного обслуживания в рамках проводимых научных исследований и ориентированной на изучение ПМСП подготовки кадров;

- изучение населением, политическими и руководящими деятелями, решения которых касаются ПМСП, вопросов, связанных с характером и задачами первичной медико-санитарной помощи;

- планирование учебных программ, обеспечение эффективности учебного процесса, а также решимости руководящих органов работать в направлении развития ПМСП; разработку свода практических требований к научной и специальной подготовке в области ПМСП, предъявляемых к выпускникам медицинских вузов;

- использование соответствующих методов преподавания, проработанных в ходе планирования и анализа учебных программ, а также при оценке уровня подготовки студентов, учет многосекторального и многодисциплинарного характера работы будущего специалиста при планировании обучения и в ходе подготовки;

- официальную договоренность между медицинской школой и службами, работающими в медико-санитарной и родственной областях, относительно проведения школой учебных и исследовательских мероприятий в одном из достаточно крупных и населенных районов, что позволило бы привлечь работников первичной медико-санитарной помощи к обучению и контролю за ходом подготовки отдельных учащихся и небольших групп студентов;

- развитие деятельности по обучению населения ПМСП должно основываться на критериях, разработанных в региональной стратегии (пункт 20), в частности, в области обеспечения участия населения в проводимых мероприятиях, многодисциплинарной бригадной работы и индивидуального подхода к охране собственного здоровья;

- детальную разработку функций и педагогических навыков работников факультетов ПМСП наряду с учебными программами для преподавательского состава.

ПМСП в структуре медицинской школы

Хотя создание специальных кафедр или отделений ПМСП представляется возможным, такой подход рискует привести к ограничению преподавания медико-санитарной помощи рамками академической кафедральной деятельности, тогда как многие учебные кафедры могли бы внести свой вклад в подготовку студентов, что необходимо для усвоения ими, в первую очередь, практических профессиональных знаний, а не теоретических постулатов. Была предложена такая форма организации работы, которая позволит связать воедино факультеты и отделения медицинских школ, другие медико-санитарные дисциплины, а также, возможно, и кафедры университетов, активно работающие в области ПМСП. Это позволит создать мощный сектор медицинских факультетов, непосредственно отвечающих за подготовку в области ПМСП, научные исследования и работу среди населения. Структура медицинских школ должна включать в себя отделения общей практики, социальной медицины, профессиональной гигиены, эпидемиологии, гериатрии, долгосрочного обслуживания и социальной психиатрии. Такая структурная организация не должна вести к поляризации специализированных клиник и медицинских учебных заведений, ориентированных на выпуск специалистов для обслуживания населения. Она должна обеспечивать участие клинических учреждений в совершенствовании подготовки студентов по клиническим дисциплинам, необходимым для врача общей практики. Это сотрудничество в рамках подготовки студентов должно строиться на определении общих и специальных дисциплин с тем, чтобы студенты имели возможность получить квалифицированную клиническую подготовку, необходимую для врача общей практики, работающего в области ПМСП, а не просто фрагментарные знания о сложнейшей технологии, используемой специализированными медицинскими службами. Для решения этой задачи на определенных этапах учебной работы понадобится участие старших преподавателей-клиницистов, работающих в учреждениях первичной медико-санитарной помощи.

Кроме групп, работающих в области профилактического обеспечения населения и специализированной клинической деятельности, третьей "представительной группой" в медицинских школах могла бы быть группа, занимающаяся вопросами руководства и развития, уже действующая в

некоторых продвинутых медицинских школах. Эта группа могла бы содействовать расширению компетенции и знаний о путях решения возникающих проблем, а также устранению присущей педагогической работе кафедральности, не совместимой с практикой подготовки кадров в области ПМСП. Она могла бы также содействовать членам факультетов, ответственным за ПМСП, в осуществлении руководства децентрализованными коммунальными учебными программами в этой области. В частности, она могла бы оказаться подспорьем при проведении учебных мероприятий и контроле за подготовкой для большого числа работников ПМСП, которые понадобятся медицинским школам в ходе практического обучения студентов.

Университеты и ПМСП

Поскольку здравоохранения населения не возможно достичь усилиями лишь одного медико-санитарного сектора, необходимо изучить и использовать весь потенциал университетов (или всей системы высшего образования). Группы ПМСП в медицинских школах могли бы иметь надежных союзников в лице руководящих органов университетов, а также различных факультетов и отделений вузов, например, по экономике, социологии, политическим наукам, географии, биоинженерии, архитектуре, городскому строительству и сельскому хозяйству. Для проведения совместных межфакультетских исследований университеты могли бы выделить соответствующие средства.

Рекомендации

1. В каждой стране необходимо создать орган по координации развития подготовки персонала здравоохранения в области ПМСП, который также действовал бы в качестве банка данных и информации о национальных и международных мероприятиях, проводимых в сфере обучения ПМСП.

2. Стипендии ВОЗ следует использовать для содействия проведению в странах мероприятий по развитию подготовки национальных кадров в области ПМСП.

3. Европейскому региональному бюро ВОЗ следует осуществлять тесное сотрудничество с международными профессиональными ассоциациями в Европе, занимающимися вопросами переориентации медицинского обучения в направлении ПМСП.

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Primary health care is the key to attaining WHO's goal of health for all by the year 2000. In the European Region of WHO the strategy for health for all embodies three principal thrusts: promoting healthy lifestyles, reducing preventable conditions, and providing adequate health care that is accessible to all. The countries of the Region are now at different stages of preparing their own national strategies and corresponding primary health care approaches, and one crucial aspect of this planning is the reorientation of medical and nursing education to accommodate the changes in medical practice that these will demand.

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- **multidisciplinary and multisectoral teamwork**
- **extending health care coverage to underserved, vulnerable and deprived families and groups**
- **associating themselves as health professionals with action that the community takes to identify and deal with the primary causes of ill health and to reduce the effects of chronic disease and disability.**

This report presents a clear picture of where Europe should be going in its medical education policies, the problems to be overcome, and the conditions, including research, needed to bring about the necessary reorientation. It should be read by all those — in government, universities and medical schools — who are concerned with the future of medical education in Europe.